United Nations E/CN.7/2016/8

# Economic and Social Council

Distr.: General
20 January 2016

Original: English

**Commission on Narcotic Drugs**
**Fifty-ninth session**
Vienna, 14-22 March 2016
Item 5 (a) of the provisional agenda*
**Implementation of the Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem: follow-up to the high-level review by the Commission on Narcotic Drugs, in view of the special session of the General Assembly on the world drug problem to be held in 2016 — demand reduction and related measures**

## Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users

### Report of the Executive Director

*Summary*

The present report has been prepared pursuant to Commission on Narcotic Drugs resolution 49/4, entitled "Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users". It provides an overview of the response of the United Nations Office on Drugs and Crime (UNODC) to the spread of HIV/AIDS and other blood-borne diseases among people who use drugs, including a summary of activities implemented by UNODC in 2014 and 2015. It contains recommendations and indicates gaps and remaining challenges in responding to HIV/AIDS and other blood-borne diseases among people who use drugs.

UNODC delivers technical assistance in full compliance with the relevant declarations, resolutions and decisions of United Nations bodies and assists Member States, civil society organizations and other partners in developing, adopting and implementing strategies and programmes on HIV/AIDS related to drug use, particularly for people who inject drugs, and policies and programmes for HIV/AIDS prevention, treatment, care and support in prisons and other closed settings.

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# I. Introduction

1. The present report has been prepared pursuant to Commission on Narcotic Drugs resolution 49/4, entitled "Responding to the prevalence of HIV/AIDS and other blood-borne diseases among drug users", in which the Commission invited Member States, in accordance with their national legislation:

(a) To give the utmost consideration to the development of demand reduction actions based on studies and research that demonstrate the efficacy and efficiency of drug-related treatment and prevention;

(b) To adopt drug-related health policies that facilitate prevention of drug abuse and access by drug users to different types of prevention, treatment and care for drug dependency, drug-related HIV/AIDS, hepatitis and other blood-borne diseases;

(c) To enhance efforts to promote access to health and social care for drug users and their families without discrimination of any kind and, where appropriate, to cooperate with relevant non-governmental organizations;

(d) To provide access, as appropriate and in the framework of the pertinent national policies, to medications, vaccines and other measures that are consistent with international drug control treaties and have been shown to be effective in reducing the risk of HIV/AIDS, hepatitis and other blood-borne diseases among injecting drug users, under the supervision of competent authorities or institutions.

2. Also in its resolution 49/4, the Commission endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, as well as related decisions of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS (UNAIDS). In the same resolution, the Commission requested the United Nations Office on Drugs and Crime (UNODC), in conformity with the *UNAIDS Technical Support Division of Labour* document, to provide technical assistance, upon request and subject to the availability of extrabudgetary resources, to Member States to develop comprehensive demand reduction strategies and measures, including HIV/AIDS prevention and care in the context of drug abuse, that are consistent with the international drug control treaties. Also in that resolution, the Commission requested the Executive Director of UNODC to report to it biennially, starting at its fifty-first session, on the implementation of the resolution.

# II. Epidemiological situation and required responses

3. In 2014, there were 36.9 million (range: 34.3-41.4 million) people living with HIV. That represents an increase from previous years, as more people are receiving the life-saving antiretroviral therapy. As at March 2015, 15 million people living with HIV were accessing antiretroviral therapy, up from 13.6 million in June 2014. Worldwide, 2 million (range: 1.9-2.2 million) people became infected with HIV in 2014, down from 3.1 million (range: 3.0-3.3 million) in 2000, which represents a 35 per cent decline in new HIV infections since 2000.[1]

[1] UNAIDS, "Fact sheet 2014: global statistics" (Geneva, 2015).

4. Injecting drug use has been documented in at least 158 countries, and it continues to drive the spread of the HIV epidemic in many countries around the world. The joint UNODC/World Health Organization (WHO)/UNAIDS/World Bank estimate for 2013 of the number of people who inject drugs worldwide was 12.19 million (range: 8.48-21.46 million); of those, about 1.65 million (range: 0.92-4.42 million), or 13.5 per cent of people who inject drugs, were estimated to be living with HIV.

5. The highest prevalence of injecting drug use continues to be found in Eastern and South-Eastern Europe, where 1.27 per cent of the general population aged 15-64 is estimated to be injecting drugs, a rate nearly five times the global average. Approximately 40 per cent of the estimated global total number of people who inject drugs living with HIV reside in Eastern and South-Eastern Europe. A further 20 per cent reside in East and South-East Asia and 12 per cent reside in South-West Asia, the region with the highest prevalence of HIV among people who inject drugs.

6. Hepatitis C infection prevalence among people who inject drugs was estimated at 52 per cent for 2013. That means that 6.3 million people who inject drugs are infected with hepatitis C, a rate 25 times higher than among the general population. Prisons and other closed settings are high-risk environments for both HIV and hepatitis C transmission.[2]

7. Despite the progress seen in some areas of the global response to HIV, the global community largely missed achieving the global target of halving the transmission of HIV among people who inject drugs by 2015.[3] Globally, new HIV infections among people who inject drugs have declined only slightly (by around 10 per cent): from an estimated 110,000 (range: 97,000-123,000) new HIV infections in 2010 to 98,000 (range: 85,000-111,000) in 2013.[4]

8. It is estimated that about 70 million people (range: 37-103 million) have used amphetamine-type stimulants, cocaine and 3,4-methylenedioxymethamphetamine (MDMA, commonly known as "ecstasy") at least once in the past 12 months.[5] The most common HIV risk faced by people who use amphetamine-type stimulants and/or "ecstasy" and "crack" cocaine involves high-risk sexual behaviours with partners from groups with high HIV prevalence and incidence, but it is difficult to quantify the exact role of use of stimulants in increasing HIV infection rates. Although there appears to be great variability on HIV prevalence rates among non-injecting amphetamine-type stimulant users, ranging from less than 1 per cent[6]

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[2] *World Drug Report 2015* (United Nations publication, Sales No. E.15.XI.6).

[3] Target contained in the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (General Assembly resolution 65/277, annex).

[4] UNAIDS Programme Coordinating Board, "Halving HIV transmission among people who inject drugs: background note", document UNAIDS/PCB (35)/14.27.

[5] *World Drug Report 2015*.

[6] Sasha Uhlmann and others, "Health and social harms associated with crystal methamphetamine use among street-involved youth in a Canadian setting", *American Journal on Addictions*, vol. 23, No. 4 (2014), pp. 393-398.

to 18.50 per cent,[7] the evidence points towards a positive association between amphetamine-type stimulant use and HIV risk and transmission.[8,9,10,11]

9. Women who inject drugs are often more vulnerable to HIV than their male counterparts. A review of 117 studies from 14 countries with a high prevalence of HIV among people who inject drugs (greater than 20 per cent) found an overall higher prevalence of HIV among women who inject drugs compared with men who inject drugs.[12] Females are more likely to be stigmatized and marginalized by society and are more likely to hide their injecting drug use behaviour. Unsafe injecting practices may be more common among females given the greater difficultly in accessing needle and syringe programmes or treatment for drug dependence and the lack of services tailored to women's needs. The combined risks of unsafe injecting and unprotected sex substantially elevate the risks of HIV transmission among females.

10. In prisons, unsafe drug injecting practices are among the major risk factors for the transmission of blood-borne infections such as HIV and hepatitis C. It has been estimated that between 56 and 90 per cent of people who inject drugs will be incarcerated at some stage and that people who use or inject drugs may constitute up to 50 per cent of the population in closed settings. Yet, drug dependence treatment, opioid substitution therapy and needle and syringe programmes in prisons are rare and often completely lacking. Very high levels of sharing of needles and syringes have been documented among people who inject drugs in prisons, for example, 56 per cent in Pakistan, 66 per cent in the Russian Federation, 70-90 per cent in Australia, 78 per cent in Thailand and 83-92 per cent in Greece.[13]

11. The accumulated evidence collected over the past 30 years points to the effectiveness of harm reduction, which, for the purpose of the present report, is understood to refer to the set of the measures defined by WHO, UNODC and UNAIDS[14] to prevent HIV and other blood-borne infections among people who inject drugs (also referred to in the Commission for Narcotic Drugs resolution 56/6) for the provision of comprehensive prevention programmes and treatment, care and

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[7] Wendee M. Wechsberg and others, "Contextualizing gender differences and methamphetamine use with HIV prevalence within a South African community", *International Journal of Drug Policy*, vol. 25, No. 3 (2014), pp. 583-590.

[8] Grant Colfax and others, "Amphetamine-group substances and HIV", *The Lancet*, vol. 376, No. 9739 (2010), pp. 458-474.

[9] Louisa Degenhardt and others, "Meth/amphetamine use and associated HIV: implications for global policy and public health", *International Journal of Drug Policy*, vol. 21, No. 5 (2010), pp. 347-358.

[10] Isabel Tavitian-Exley and others, "Influence of different drugs on HIV risk in people who inject: systematic review and meta-analysis", *Addiction*, vol. 110, No. 4 (2015), pp. 572-584.

[11] Nga T. T. Vu, L. Maher and I. Zablotska, "Amphetamine-type stimulants and HIV infection among men who have sex with men: implications on HIV research and prevention from a systematic review and meta-analysis", *Journal of the International AIDS Society*, vol. 18, No. 1.

[12] Don C. Des Jarlais and others, "Are females who inject drugs at higher risk for HIV infection than males who inject drugs: an international systematic review of high seroprevalence areas", *Drug and Alcohol Dependence*, vol. 124, Nos. 1 and 2 (2012), pp. 95-107.

[13] Kate Dolan and others, "People who inject drugs in prison: HIV prevalence, transmission and prevention", *International Journal of Drug Policy*, vol. 26, Suppl. No. 1 (2015), pp. S12-S15.

[14] *WHO/UNODC/UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users* (Geneva, World Health Organization, 2009).

related support services, including for co-occurring common mental health disorders, in full compliance with the international drug control conventions and in accordance with national legislation, taking into account all relevant General Assembly resolutions.

12. However, the implementation of such programmes remains at very low levels of coverage in many regions of the world.[15] A recent review of the global coverage of services for needle and syringe programmes, opioid substitution therapy and antiretroviral therapy shows that 91 countries include their provision in national policies, but the implementation of those services often does not reach the levels of quality and coverage needed in order to be fully effective. With regard to prisons, there are political, legal and regulatory barriers to introducing or expanding evidence-based HIV prevention, treatment and care programmes in a number of countries. For example, in 2014, only two countries from the European Union/European Economic Area (Luxembourg and Spain) reported that needle and syringe programmes were available in all prisons.[16]

## III. Technical assistance provided by the United Nations Office on Drugs and Crime with regard to HIV/AIDS in 2014 and 2015

13. UNODC provides technical assistance to Member States in the area of HIV/AIDS in full compliance to the relevant declarations, resolutions and decisions adopted by the General Assembly, the Economic and Social Council, the Commission on Narcotic Drugs, the Commission on Crime Prevention and Criminal Justice and the UNAIDS Programme Coordinating Board. In 2014 and 2015, the work of UNODC on HIV/AIDS was guided by the UNAIDS strategy 2011-2015, which was aimed at advancing global progress in achieving country-set targets for universal access to HIV prevention, treatment, care and support and to halt and reverse the spread of HIV and contribute to the achievement of the targets set in the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, and the Millennium Development Goals.

14. UNODC, a co-sponsor of UNAIDS, is the convening agency in the UNAIDS family for protecting people who use drugs from becoming infected with HIV and ensuring access to comprehensive HIV services for people in prisons and other closed settings, in accordance with the UNAIDS Division of Labour.[17] The Division of Labour is used to accentuate the comparative advantages of the Joint Programme and to leverage organizational mandates and resources to work collectively to deliver results, including by strengthening joint working and maximizing partnerships.

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[15] David P. Wilson and others, "The cost-effectiveness of harm reduction", *International Journal of Drug Policy*, vol. 26, Suppl. No. 1 (2015), pp. S5-S11.

[16] European Centre for Disease Prevention and Control, *Thematic Report: Prisoners — Monitoring Implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 Progress Report* (Stockholm, 2015).

[17] *UNAIDS Division of Labour: Consolidated Guidance Note — 2010* (Geneva, 2011).

15. To support reaching the target of reducing transmission of HIV among people who inject drugs by 50 per cent by 2015, contained in the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS and affirmed by the Commission on Narcotic Drugs in its resolution 56/6, in 2014 and 2015, UNODC concentrated its efforts and resources in 24 high-priority countries for injecting drug use and HIV. The Office had selected those countries in 2013 in consultation with national stakeholders, including civil society organizations.[18] The Office supported a rapid scaling-up of the delivery of harm reduction services, including advocacy, technical assistance and capacity-building, in order to combat the HIV epidemic in those countries. The countries were selected following an analysis of: (a) epidemiological data on injecting drug use and HIV burden, including in prisons; and (b) country readiness regarding the policy and legislative environments allowing essential services such as needle and syringe programmes, opioid substitution therapy, condom programmes and antiretroviral therapy and the resource environment, including international and domestic funding and human resources.

16. At the global policy level, the decisions made by the Commission on Narcotic Drugs, the Programme Coordinating Board of UNAIDS and the Economic and Social Council in 2009 reflect the common understanding within United Nations entities about required responses to the HIV epidemic among people who inject drugs. The comprehensive package of HIV prevention, treatment and care services for people who inject drugs contains the following:[19]

(a) Needle and syringe programmes;

(b) Opioid substitution therapy and other evidence-based drug dependence treatment;

(c) HIV testing and counselling;

(d) Antiretroviral therapy;

(e) Prevention and treatment of sexually transmitted infections;

(f) Condom programmes for people who inject drugs and their sexual partners;

(g) Targeted information, education and communication for people who inject drugs and their sexual partners;

(h) Prevention, vaccination, diagnosis and treatment for viral hepatitis;

(i) Prevention, diagnosis and treatment of tuberculosis.

[18] The high-priority countries for injecting drug use and HIV (2013-2015) were: Argentina, Belarus, Brazil, China, Egypt, India, Indonesia, Iran (Islamic Republic of), Kazakhstan, Kenya, Kyrgyzstan, Morocco, Myanmar, Nigeria, Pakistan, the Philippines, the Republic of Moldova, South Africa, Tajikistan, Thailand, Ukraine, United Republic of Tanzania (Zanzibar), Uzbekistan and Viet Nam.

[19] *WHO/UNODC/UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users.*

## A. HIV/AIDS policy and programme development

17. In all its high-priority countries, UNODC has advocated and provided training and technical assistance for the development of AIDS policies and programmes that are evidence-informed and human rights-focused and support public health approaches for HIV prevention, treatment and care for people who use drugs, and those living in prisons and other closed settings. UNODC has engaged people who use drugs and other key partners in multisectoral, evidence-informed and open dialogues on HIV, drug policies, criminal justice and human rights, shared best practices and helped to identify how drug policies could be strengthened to ensure that the rights of people who use drugs to health care are protected and respected in the context of HIV.

18. In 2014, as Chair of the Committee of Co-sponsoring Organizations of UNAIDS, UNODC played a critical role in shaping the future of UNAIDS. In December 2014, the Programme Coordinating Board of UNAIDS requested the Executive Director of UNAIDS to update and extend the UNAIDS 2011-2015 Strategy through the fast-track period 2016-2021 and to present on that basis an updated strategy and Unified Budget, Results and Accountability Framework for approval by the Board at its thirty-seventh meeting. UNODC contributed to the development of the UNAIDS Strategy 2016-2021, which is aimed at supporting the fast-tracking of HIV/AIDS responses and ending the AIDS epidemic as a public health threat by 2030 by promoting human rights, public health, justice and equality of access to HIV services among people who use drugs and people in prisons. The Strategy was adopted by the UNAIDS Programme Coordinating Board at its thirty-seventh meeting, held in Geneva from 26 to 28 October 2015. At the same meeting, the Board also approved the Unified Budget, Results and Accountability Framework for 2016-2021, which will translate the strategy into action at the national, regional and global levels.

19. Upon request, UNODC supported the review of national laws and policies concerning illicit drugs, criminal justice, prisons and HIV, for example through organizing the first global consultation on HIV prevention, treatment, care and support in prison settings in Vienna in October 2014. At the two-day consultation, heads of national prison systems and heads of national AIDS programmes from 27 key countries around the globe, as well as representatives of the permanent missions in Vienna and representatives of relevant civil society organizations, United Nations organizations (UNAIDS, WHO, United Nations Development Programme (UNDP) and UNESCO) and the Global Fund to Fight AIDS, Tuberculosis and Malaria reviewed the nature and magnitude of current challenges and progress made and shared lessons learned.

20. UNODC increased the capacity of Member States to prepare for the special session of the General Assembly on the world drug problem to be held in 2016 through organizing informal discussions with regard to HIV and people who inject drugs and contributed to bridging the gap between policy and science with regard to drug use and HIV, for example through organizing a scientific consultation entitled "Science addressing drugs and health: state of the art" on the margins of the fifty-seventh session of the Commission on Narcotic Drugs. A statement resulting from the consultation was presented at the high-level segment of the fifty-seventh session.

21. During the fifty-seventh session of the Commission, UNODC organized side events on the following themes: "Acting for impact: UNODC high-priority countries for HIV and injecting drug use", "Harm reduction in prisons" and "Violence against women who use drugs". UNODC contributed to the implementation of the thematic session of the thirty-fifth meeting of the UNAIDS Programme Coordinating Board on the theme "Halving HIV transmission among people who inject drugs" and supported the implementation of the agenda item on HIV in prisons and other closed settings at the thirty-seventh meeting of the Board.

22. Furthermore, UNODC supported Member States in effectively addressing HIV in the context of the special session of the General Assembly on the world drug problem to be held in 2016 through organizing seven regional dialogues on drug policy and HIV that engaged national policymakers, drug control agencies, civil society and community-based organizations, and people who use drugs in an evidence-informed dialogue on HIV, drug policies and human rights.

23. In South-East Asia, UNODC conducted the third regional consultation on compulsory centres for drug users in September 2015 with nine Member States (Cambodia, China, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Thailand and Viet Nam), engaging experts representing various sectors (civil society, academia and treatment and HIV service providers) and other United Nations agencies. The consultation intensified advocacy and facilitated production of a discussion paper on transitioning from compulsory centres for drug users to voluntary community-based treatment for people who use drugs.

24. UNODC led the establishment of a new global collaboration mechanism for generating strategic information on people who inject drugs and HIV to guide policy and programme development and implementation, which improved understanding at the global, regional and country levels of the HIV epidemic among people who inject drugs through enhanced United Nations-wide global data analysis and reporting and generation of more in-depth information about the quality of current estimates and their methodology. Those efforts also resulted in the first ever joint UNODC/WHO/UNAIDS/World Bank global estimates on injecting drug use and HIV among people who inject drugs, which were published in the *World Drug Report 2014*.[20]

25. In the Middle East and North Africa, UNODC supported, for example, opioid substitution therapy feasibility studies in Egypt and the State of Palestine that are aimed at developing operational models for service delivery and the piloting of opioid substitution therapy as part of comprehensive responses to preventing HIV among people who inject drugs in addition to reducing other harms associated with drug use, and for promoting evidence-based drug dependence treatment and the social reintegration of people who inject drugs. The studies facilitated the start of an opioid substitution therapy programme in the State of Palestine; a population size estimation study of the key at-risk population groups in Egypt; an epidemiological assessment of HIV, tuberculosis, co-infections and drug use in selected prisons in South Sudan; and an assessment of HIV and the drug use situation in five Moroccan prisons.

[20] UNODC (United Nations publication, Sales No. E.14.XI.7).

26. In East and Southern Africa, UNODC implemented, in collaboration with UNAIDS, the Ethiopian Public Health Institute and other national counterparts, a study in Addis Ababa generating strategic information on the role of injecting drug use in the spread of HIV in Ethiopia and in the United Republic of Tanzania. The Office provided technical support to the national AIDS control programme for the development of HIV monitoring and evaluation tools for people who use or inject drugs and for a protocol to assess drug use prevalence in prisons on the mainland of the United Republic of Tanzania. It also provided technical assistance for implementing a rapid assessment of HIV prevalence and HIV-related risks among people who inject drugs in five South African cities, which raised awareness and supported advocacy on the need for evidence-informed and human rights-based HIV services for people who inject drugs in South Africa.

## B. Scaling-up HIV prevention, treatment and care and the provision of support services

27. UNODC assisted Member States, civil society organizations and other partners in developing, adopting and implementing strategies and programmes on HIV/AIDS related to drug use, particularly for people who inject drugs, in line with the *WHO, UNODC, UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*, and for people living in prisons and other closed settings, in line with the UNODC/International Labour Organization (ILO)/UNDP/WHO/UNAIDS policy brief entitled "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions".[21]

28. In Central Asia, for example, with the technical support and advocacy efforts of UNODC, the protocol on the provision of opioid substitution therapy in prison settings was approved by the Ministry of Justice and the Ministry of Health in Tajikistan and training was conducted on opioid substitution therapy for policymakers and practitioners of the Penitentiary Department. In Kazakhstan, UNODC conducted information and advocacy events on opioid substitution therapy among policymakers, service providers, civil society and the media in 10 regions, which contributed to increased access to opioid substitution therapy for new clients and increased allocation to opioid substitution therapy services from domestic sources.

29. In Viet Nam, opioid substitution therapy services were successfully scaled-up with UNODC support in two provinces (Hoa Binh and Thai Nguyen), which improved service quality and contributed to the enhanced recovery process of clients. The development of a standardized national curriculum for training in drug dependence treatment was supported and over 140 service providers in key provinces were trained. In addition, advocacy for voluntary, community-based, comprehensive drug dependence treatment and care services was carried out during events organized by the Government of Viet Nam.

30. In Kenya, UNODC supported the Government with the implementation and scaling-up of evidence-based HIV services for people who inject drugs, including in

[21] UNODC (Vienna, 2013).

the development of national and county standard operating procedures for medically assisted treatment. UNODC also built and refurbished three medically assisted treatment clinics in Kenya with the potential to provide services to over 2,000 clients yearly. As at December 2015, medically assisted treatment had been initiated for 283 new clients. In addition, UNODC enhanced the service delivery for people who inject drugs through the implementation of workshops, mentorship and study tours that reached over 150 service providers, including clinical officers and staff of civil society organizations, and policymakers.

31. In South Africa, UNODC raised the awareness of key stakeholders, including law enforcement officials, about supporting the implementation of needle and syringe programmes and opioid substitution therapy, and helped to mobilize additional funding for the national authorities from the Global Fund to Fight AIDS, Tuberculosis and Malaria for the scaling-up of HIV prevention, treatment and care services for people who inject drugs.

32. UNODC support to civil society organizations has focused on the provision of technical assistance for the implementation and scaling-up of evidence-based HIV prevention, treatment and care for people who use drugs and in prison settings. In addition, UNODC activities have supported the meaningful engagement of civil society organizations in policy and programmatic discussions and decisions related to drug use and HIV, and prisons and HIV; technical assistance to review laws and policies in line with evidence, human rights and public health principles; the generation and dissemination of strategic information; strategy development; and the mobilization of resources. UNODC provided financial and technical support to over 350 civil society organizations worldwide. For example, seven grants were awarded for strategic initiatives on HIV prevention, treatment, care and support among people who inject drugs and supporting the active involvement of regional and global civil society networks in strategic HIV responses.

33. In Brazil, there is an urgent need to scale up voluntary HIV testing and counselling, including among people who use drugs and are at risk for HIV infection. In response, UNODC, in cooperation with the Ministry of Health, supported strategic projects with 38 non-governmental organizations under the initiative *Viva Melhor Sabendo* ("Live Better Knowing It") to develop education and communication health strategies for HIV prevention, treatment and care among people who regularly use cocaine and "crack" cocaine. Under the initiative, non-governmental organizations have scaled-up access to rapid oral fluid HIV testing and, as at December 2015, have provided over 28,400 people with voluntary HIV testing and counselling.

34. Also in Brazil, UNODC, jointly with the municipal AIDS programme, supported the programme of the Municipality of Sao Paulo called *De Braços Abertos* ("Open Arms"), which, as at December 2015, had reached over 1,300 people who use "crack" cocaine (over 300 women and 1,000 men), many of whom are also former prisoners, and of whom nearly 10 per cent are living with HIV. The programme has provided them with job opportunities, housing (with the involvement of social care assistance) and improved access to health services.

35. In Argentina, UNODC, in partnership with the non-governmental organization Intercambios, AIDS authorities of the Province of Buenos Aires and other local partners, trained over 60 health and social care service providers and representatives

of civil society organizations in addressing the HIV risks and vulnerability of people who use drugs, improving awareness among health service providers about the rights of people who use drugs to have access to the highest level of HIV and other health services available in communities, and supporting the creation of low-threshold community-based HIV services for people who use drugs.

36. Still, in many countries with concentrated HIV epidemics among people who inject drugs, women who inject drugs have limited or no access to harm reduction for HIV prevention or general health services. UNODC and its partners continued to advance global dialogue on and focus advocacy for gender-responsive HIV programmes aimed at ensuring equitable access to HIV prevention, treatment and care services for women who use drugs and female prisoners, and for female sexual partners of men who inject drugs.

37. In Pakistan, for example, through the project "HIV/AIDS prevention, treatment and care for female injecting drug users and female prisoners in Pakistan", financed by the Government of Norway and the Organization of the Petroleum Exporting Countries Fund for International Development, UNODC delivered HIV services for women who inject drugs in nine community-based sites in Lahore, Karachi, Rawalpindi, Dera Ghazi Khan, Hyderabad, Larkana and Chitral; for female prisoners in three prisons in Lahore, Peshawar and Quetta; and for Afghan refugees in Mianwali, in Punjab Province. In partnership with government authorities and other United Nations agencies, the Office also conducted a pilot study on pharmacologically assisted treatment for opioid dependence, and shared the findings with the Narcotics Control Division and the Anti-Narcotics Force of Pakistan.

38. In Central Asia, a regional meeting on the theme "Drug use and HIV: addressing the specific needs of women who use drugs and people in prisons" was held in Dushanbe in September 2015. Participants shared good practices and country experiences in effectively addressing HIV risks including among women who use drugs in the context of a regional dialogue on drug policy and HIV in preparation for the special session of the General Assembly on the world drug problem to be held in 2016.

39. In Nepal, in 2015, with technical assistance provided by UNODC and relevant government authorities and in coordination with national and international partners, standard operating procedures were developed to support the implementation of decisions of stakeholders including the Government of Nepal, WHO and civil society partners to scale up HIV prevention, treatment and care services in prison settings and to revise and update the related policies. The procedures address the vulnerability of the prison populations to HIV and sexually transmitted infections by adopting the 15 key interventions of the comprehensive package, including opioid substitution therapy, needle and syringe programmes and condoms. It was the first State in the South Asia region to adopt those 15 interventions. Following the earthquake on 25 April 2015 that caused widespread devastation and forced some 75,000 people to move into rapidly erected relief camps, the HIV programme of UNODC provided technical assistance by providing gender-responsive HIV prevention, treatment and care services in emergency settings for people who use drugs.

## C. Development and dissemination of tools, guidelines and best practices

40. UNODC continued to collect, analyse and disseminate good practices in collaboration with relevant national and international partners, including civil society organizations, for the scaling-up of needle and syringe programmes, opioid substitution therapy and other evidence-based responses for people who use opioids and/or stimulant drugs and for people in prisons and other closed settings. Technical support was also provided to help adapt international guidance at the country and subnational levels.

41. *A Handbook for Starting and Managing Needle and Syringe Programmes in Prisons and Other Closed Settings*[22] contains inputs from more than 40 experts from different regions of the world in line with international laws and standards, published scientific evidence and best practices and provides evidence-informed recommendations and practical advice on how to advocate, start, scale up and monitor needle and syringe programmes. The Handbook illustrates how such programmes can be safely and effectively implemented across a range of closed settings to help reduce the spread of HIV, hepatitis B and hepatitis C, and how those programmes can contribute to achieving other individual and public health benefits.

42. UNODC enhanced the capacity of service providers to deliver evidence-informed, gender-sensitive services for women who inject drugs, including through producing and disseminating, in partnership with WHO, the United Nations Entity for Gender Equality and the Empowerment of Women and the International Network of People who Use Drugs, a policy brief entitled "Women who inject drugs and HIV: Addressing specific needs".

43. UNODC reinforced coordination among national authorities, including health, criminal justice and law enforcement authorities, and civil society through the development and dissemination of the *Training Manual for Law Enforcement Officials on HIV Service Provision for People who Inject Drugs*.

44. UNODC led the development of UNAIDS guidance notes for applicants to the Global Fund to Fight AIDS, Tuberculosis and Malaria and other funds entitled "Services for people who inject drugs"[23] and "Services for people in prisons and other closed settings",[24] in collaboration with UNAIDS, WHO and UNDP.

45. Together with the Swiss Federal Office of Public Health, the International Committee of the Red Cross and the Pompidou Group of the Council of Europe, UNODC supported production of the publication *Prisons and Health*,[25] led by the WHO Regional Office for Europe, which provided guidance for prison health professionals and policymakers on how to improve the health of people in prison and how to reduce their health risks, including with regard to HIV, hepatitis B, hepatitis C and tuberculosis.

46. UNODC led initiatives that enhanced the technical skills of government and civil society staff, strengthened national monitoring and evaluation of harm

[22] UNODC (Vienna, 2014).
[23] Geneva, 2014.
[24] Geneva, 2014.
[25] WHO (Copenhagen, 2014).

reduction for HIV prevention among people who inject drugs and improved the availability and quality of data on injecting drug use and HIV. Studies and assessments supported by UNODC promoted development and advocacy for evidence-informed strategies, policies and programmes, and helped the prioritization and costing of harm reduction activities, in partnership with civil society.

47. UNODC identified and addressed country-level gaps with regard to the quality of population size estimates of people who inject drugs and HIV. For example, UNODC, jointly with the World Bank, implemented a project entitled "Population size estimation of people who inject drugs in selected high-priority countries", with the financial contribution of the German Agency for International Cooperation (GIZ), which reviewed existing estimates in 10 countries, and the methodology used to reach them, in consultation with country stakeholders, civil society organizations and other partners, and provided recommendations on how to improve them. Joint efforts were made with UNAIDS, WHO, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners to ensure synergies and the complementarity of monitoring and evaluation activities.

48. UNODC supported a workshop to improve the quality of estimates related to the number of people who inject drugs. The workshop was organized together with the World Bank and the International Network of People who Use Drugs and was held during the twentieth International AIDS Conference, held in Melbourne, Australia, from 20 to 25 July 2014. The workshop was attended by over 400 delegates from several high-priority countries for injecting drug use and HIV worldwide.

49. In Central Asia, UNODC and the World Bank jointly implemented a regional consultation (held in Astana in June 2014) with representatives of national narcology centres, AIDS centres, drug control agencies and civil society organizations from Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan, followed by three country-level workshops on population size estimation methods, data analysis and reporting with regard to people who inject drugs and HIV (held in November 2014). In Eastern Europe, a country-level workshop on methods for size estimation of people who inject drugs was also held in Minsk in March 2015).

50. UNODC further disseminated evidence-based good practices in drug dependence treatment in five regions (Africa, Central Asia, Middle East and North Africa, Latin America and South-East Asia) through local and national networks of government agencies, treatment centres, primary health-care services, universities and non-governmental organizations, and improved access to drug dependence treatment alongside social integration and rehabilitation. The work focused on advocacy, capacity-building and service improvement as means of promoting a sound understanding of drug dependence treatment and care and the recognition of drug dependence as a health disorder that requires a multidisciplinary and comprehensive approach.

51. For example, in Pakistan, UNODC supported a provincial consultation on prisons and HIV in cooperation with the provincial AIDS control programme and the office of the Inspector General of Prisons that was held in Karachi in September 2015 and which initiated, in one prison, the development of a model on how to provide HIV and drug dependence treatment services in prison settings.

In Indonesia, UNODC, jointly with UNAIDS, supported the National AIDS Commission in documenting community-based drug dependence treatment services and reviewing the barriers for scaling-up opioid substitution therapy among clients and service providers in eight cities in five provinces. In the Islamic Republic of Iran, the guidelines developed by UNODC on HIV prevention among amphetamine-type stimulant users in drop-in centres was piloted among 400 clients at 11 drop-in centres in 11 cities in 2015, which helped to reduce high-risk behaviour among those clients who used amphetamine-type stimulants.

## D. Legal and policy reviews and building capacity among law enforcement officials

52. UNODC facilitated the review and adaptation of national legislation and policies concerning narcotic drugs, criminal justice, prison management and HIV, provided training and produced and disseminated guidelines and tools for improving equitable access to HIV prevention, treatment and care services, including sterile needles and syringes, and condoms, for example, for people who inject drugs and people in prisons and other closed settings, in several countries in Eastern Europe, Central Asia, South and South-East Asia, North Africa and the Middle East, Southern and East Africa, and Latin America.

53. UNODC enhanced interaction and partnerships between the law enforcement sector and civil society organizations by implementing a training programme in the context of drug use and HIV that reached over 2,100 law enforcement officers and representatives of civil society and community-based organizations and the health, social, educational and justice sectors in 21 countries (Afghanistan, Argentina, Belarus, Brazil, India, Iran (Islamic Republic of), Kazakhstan, Kenya, Kyrgyzstan, Myanmar, Nigeria, Pakistan, Philippines, Republic of Moldova, South Africa, Tajikistan, Thailand, Ukraine, United Republic of Tanzania, Uzbekistan and Viet Nam). The programme has contributed to making HIV training part of the curricula of national police academies and enhancing partnerships in harm reduction for HIV prevention between relevant sectors.

54. For example, UNODC implemented a regional training session for representatives of the police academies of Kazakhstan, Kyrgyzstan, Tajikistan and Uzbekistan on HIV service provision for people who inject drugs. Subsequently, with support provided by UNODC, the training manual was translated, adapted and integrated into the training curricula of police academies in Kazakhstan, Tajikistan and Uzbekistan. In the Republic of Moldova, UNODC supported the Ministry of the Interior in developing an operational manual for the police on HIV and people who inject drugs, which was used as part of the police field work in the country.

55. In India, UNODC conducted a workshop held in New Delhi in November 2014, in partnership with the National AIDS Control Organisation, the Narcotics Control Bureau and UNAIDS to enhance partnerships between law enforcement and civil society organizations in the context of drug use and HIV and building the capacity of law enforcement officers, public health officials and civil society service providers. In Pakistan, UNODC raised awareness of harm reduction for HIV prevention among law enforcement officers at the Punjab Police Training Academy.

56. In Ukraine, the sectoral action plan on responding to HIV and AIDS among police personnel and staff for 2015-2018, developed with the technical support of UNODC under the United States of America Agency for International Development (USAID)-funded Penitentiary, Law Enforcement and Drug Sectors Government Efficiency in HIV Response (PLEDGE) project, with the close engagement of the Technical Working Group on HIV and Law Enforcement in Ukraine, was adopted in 2015. The action plan outlines the key roles and accountability of the police sector with regard to the implementation of the national AIDS programme of Ukraine for the period 2014-2018, including as it relates to scaling-up opioid substitution therapy and the enhancement of intersectoral cooperation between police, health-care providers, social services and civil society organizations in promoting access to HIV services for people who inject drugs.

57. In Nigeria, UNODC, jointly with the National Agency for the Control of AIDS, initiated a legal and policy review to facilitate the provision of harm reduction for HIV prevention among people who inject drugs, including in prison settings. Together with WHO, UNODC provided technical support for the development of the national policy on control of viral hepatitis B and C, including for people who inject drugs and prisoners, and for its launch by the Federal Ministry of Health and the national HIV/AIDS and sexually transmitted diseases control programme.

58. In Viet Nam, UNODC, with its partners, assisted in the review of existing national policies on prison health, provided technical advice and disseminated international guidelines for HIV service provision in prison settings, which facilitated the opening of the first methadone maintenance therapy service unit in a prison setting in the country in August 2015. Also in Viet Nam, UNODC supported the People's Police Academy in adapting a training curriculum on harm reduction for HIV prevention for law enforcement officials. The curriculum was approved by the Academy in August 2015 and is currently used in the training of police officials nationwide.

59. UNODC, jointly with UNAIDS, UNDP, the United Nations Population Fund, WHO and other partners contributed to the implementation of the global consultation on police and HIV between representatives of police, civil society and HIV programmes, convened by the Law Enforcement and HIV Network and co-organized by the Centre for Law Enforcement and Public Health, the International Development Law Organization and Birkbeck School of Law at the University of London. The consultation, organized in conjunction with the second International Conference on Law Enforcement and Public Health, held in Amsterdam, from 5 to 8 October 2014, increased awareness of the need to establish, develop and sustain partnerships between people living with and affected by HIV, HIV service providers, other health professionals and law enforcement officials.

## IV. Conclusions and recommendations

60. At its thirty-seventh meeting, held in Geneva from 26 to 28 October 2015, the Programme Coordinating Board of UNAIDS adopted the UNAIDS Strategy 2016-2021, which calls for fast-tracking the HIV response to reach the sustainable development target of ending the AIDS epidemic as a public health

threat by 2030. In line with the UNAIDS Strategy 2016-2021, fast-tracking the global AIDS response will require efforts across several sustainable development goal areas: good health (Sustainable Development Goal 3), gender equality (Goal 5), reduced inequalities (Goal 10), just and inclusive societies (Goal 16) and global partnerships (Goal 17).

61. However, the AIDS response can only be fast-tracked if the right of all people to access high-quality HIV services without discrimination is effectively promoted, the specific barriers faced by key populations, including people who use drugs and people in prisons and other closed settings, in accessing evidence-based, gender- and age-responsive HIV services are addressed, and the service provision for them is rapidly scaled-up using adequate, predictable and sustainable resources.

62. Drug use is a multifactorial health and social condition, which requires a humane and evidence-based approach, not punishment. Drug use and related health problems, such as HIV, hepatitis C and drug overdose, are public health issues that must be addressed first and foremost by the health-care system through an approach that is fully in line with the international drug control conventions and human rights standards.

63. It is necessary to promote measures to reduce the vulnerability to HIV and hepatitis C transmission of people who use drugs, including in prisons and other closed settings, and to eliminate stigma and discrimination, so that implementation and access to evidence-based and gender-responsive HIV and hepatitis C services for people who use drugs can be ensured.

64. All the measures included in the WHO/UNODC/UNAIDS comprehensive package of HIV prevention, treatment and care services for people who inject drugs[26] should be implemented as a whole and scaled-up through multiple service delivery models (including outreach, low-threshold drop-in centres and peer education) in order to be effective in reducing the sharing of injecting equipment and averting HIV infections. When implemented together, such interventions have also been shown to improve quality of life, decrease mortality, reduce crime and public disorder, improve social functioning and provide a bridge to drug dependence treatment. Barriers to such services should be identified and removed.

65. High prevalence of HIV and hepatitis C among people in prisons who also inject drugs, together with very low availability of and access to relevant services in prisons, is a major barrier to reducing HIV prevalence among people who inject drugs, both in prisons and in the community. Laws and policies should be in place to facilitate access to equivalent health care for people who use drugs who are serving prison sentences, with priority given to the implementation of the 15 interventions as outlined by UNODC, ILO, UNDP, WHO and UNAIDS in the policy brief entitled "HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions".

66. The provision of voluntary, evidence-based treatment and care programmes within the community for people affected by drug use disorders who are serving prison sentences has been shown to substantially increase recovery and reduce recidivism and decrease the risk for the transmission of HIV and other blood-borne

[26] Contained in *WHO/UNODC/UNAIDS Technical Guide for Countries to Set Targets for Universal Access to HIV Prevention, Treatment and Care for Injecting Drug Users*.

infections among people who inject drugs. For such individuals, alternatives to conviction or punishment should be considered in instances consistent with the international legal framework.

67. Compulsory centres for drug users have been proved to be ineffective in reducing drug use and the risk of HIV and other blood-borne infections. Such centres should be replaced by voluntary, evidence-informed and rights-based health and social services that are offered in the community.

68. Women who inject drugs often have higher rates of HIV than their male counterparts. Still, in many countries with concentrated HIV epidemics among people who inject drugs, women who inject drugs have limited or no access to HIV services, including evidence-based drug dependence treatment services, or rehabilitation or general health-care services. Where such services exist, they are often not responsive to the specific needs of women. It is essential to ensure equitable access to evidence-based HIV prevention, treatment and care services for women who use drugs, including in prisons and other closed settings.

69. Responses to HIV among people who use amphetamine-type stimulants and cocaine and who are at risk for HIV should be intensified based on the epidemiological situation in each country. The efforts should take into account both injecting and non-injecting use of those drugs and their specific vulnerabilities and risks, including the interaction of poverty, marginalization and sex work.

70. UNODC calls on States to significantly and urgently intensify efforts in their responses to HIV among people who use drugs, including in prison settings, through increasing financial allocations from both international and national sources; focusing on high-priority locations; implementing evidence and human rights-based interventions to deliver the greatest impact; utilizing innovations and multiple service delivery models for more targeted, sustainable and accountable responses; intensifying partnerships between health, criminal justice, law enforcement, civil society and other sectors to address the determinants of vulnerabilities, including discrimination and gender inequality, affecting people who use drugs; and integrating and prioritizing both public and individual health to end AIDS as a public health threat by 2030, under the 2030 Agenda for Sustainable Development.

United Nations E/CN.7/2016/9

Economic and Social Council

Distr.: General
22 February 2016

Original: English

**Commission on Narcotic Drugs**
**Fifty-ninth session**
Vienna, 14-22 March 2016
Item 6 (b) of the provisional agenda*
**Implementation of the international drug control treaties: changes in the scope of control of substances**

# Changes in the scope of control of substances

## Note by the Secretariat

*Summary*

The present document contains recommendations for action to be taken by the Commission on Narcotic Drugs pursuant to the international drug control treaties. In accordance with article 3 of the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, the Commission will have before it for consideration a proposal from the World Health Organization concerning a recommendation to place acetylfentanyl in Schedules I and IV and to place MT-45 in Schedule I of that Convention.

In accordance with article 2 of the Convention on Psychotropic Substances of 1971, the Commission will have before it for consideration a proposal from the World Health Organization concerning a recommendation to place para-Methoxymethylamphetamine (PMMA) in Schedule I and a recommendation to place α-Pyrrolidinovalerophenone (α-PVP), para-Methyl-4-methylaminorex (4,4'-DMAR) and methoxetamine (MXE) in Schedule II of that Convention. It will also have before it for consideration a recommendation to place phenazepam in Schedule IV of that Convention.

The present document contains comments provided by Governments on economic, social, legal, administrative and other factors relevant to the proposed scheduling under the 1961 Convention and the 1971 Convention.

* E/CN.7/2016/1.

V.16-01050 (E) 260216 290216

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# I. Consideration of the notification from the World Health Organization concerning scheduling under the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol

1. Pursuant to article 3, paragraphs 1, 3 and 5 of the Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol, the Director-General of the World Health Organization (WHO), in her correspondence dated 7 December 2015, notified the Secretary-General of the United Nations that WHO recommended that acetylfentanyl be placed in Schedule I and Schedule IV of the 1961 Convention. It also recommended that MT-45 be placed in Schedule I of that Convention (see annex for the relevant extract of that notification).

2. In accordance with the provisions of article 3, paragraph 2, of the 1961 Convention, the Secretary-General transmitted to all Governments a note verbale dated 30 December 2015, annexing the notification and the information submitted by WHO in support of that recommendation.

3. As at 19 February 2016, the following 15 Governments had provided comments on economic, social, legal, administrative or other factors relevant to the recommended scheduling of those substances: Algeria, Austria, Colombia, Côte d'Ivoire, Croatia, El Salvador, Germany, Japan, Mexico, Morocco, Poland, Russian Federation, Spain, Switzerland and Turkmenistan.

4. The Holy See also provided comments on economic, social, legal, administrative or other factors relevant to the recommended scheduling of those substances.

5. The Government of Algeria indicated its support for the scheduling recommendations by WHO and reported that existing evidence justified the placement of the substances under international control.

6. The Government of Austria reported that it was facing difficulties in legally regulating new psychoactive substances, including those to be discussed by the Commission on Narcotic Drugs at its fifty-ninth session. While it agreed that effective measures against the increasingly rapid emergence of such substances were important, measures at the national level alone were insufficient and effective cooperation and coordination between all States was crucial. The Government of Austria indicated that it considered it necessary to develop new, tailored instruments and mechanisms to tackle the phenomenon of new psychoactive substances, addressing the issue at its roots, hindering producers and dealers from rapidly replacing one substance by other substances as soon as they were legally placed under control. The New Psychoactive Substances Act of 2012 had pursued a broad generic approach, defining classes of chemical substances, while targeting offences and criminal sanctions at the supply side only (production of new psychoactive substances and their distribution on the consumer market). The law further encouraged open talk about consumption behaviours from a public health perspective. The Government of Austria further reported that those substances recommended for being placed under international control that were not yet covered by the 2012 Act would be incorporated by an amendment.

7. The Government of Colombia reported that none of the substances recommended for international control had approved medical uses in Colombia. The Ministry of Justice and Law had no objection to the scheduling of those substances, as recommended. It further indicated that inclusion of those substances in the 1961 Convention would entail their inclusion in the Criminal Code of Colombia and in national legislation governing their regulation for medical and scientific uses. While forensic laboratories had the capacity to detect those substances, it would be necessary to strengthen the capacities of the police and the judicial and forensic authorities. The Government of Colombia further expressed its hope that placing substances under international control would increase the availability of comprehensive public health measures to address their use in each country, in accordance with resolution 58/5 of the Commission on Narcotic Drugs. Lastly, the Government of Colombia stressed that the scheduling of the recommended substances would represent an opportunity to strengthen international cooperation and critically review the system of classification, evaluation and decision-making for including new substances under international control and, where appropriate, propose any adjustments necessary based on scientific evidence that could be generated once those substances were placed in the schedules, in implementation of resolutions 58/7 and 58/11 of the Commission on Narcotic Drugs.

8. The Government of Côte d'Ivoire indicated that it did not have any recent information on medical or scientific use of the substances recommended by WHO for scheduling. To prevent any illicit traffic and diversion, it agreed to placing those substances under international control.

9. The Government of Croatia reported that no seizures of acetylfentanyl had been notified in Croatia and the substance was not placed under national control. If other countries were to present evidence of wider abuse at the global level, Croatia would support scheduling of that substance. MT-45 was already placed under national control, in Schedule I of the List of Narcotic Drugs and Plants.

10. The Government of El Salvador indicated that it had no records on the use or consumption of those substances. The National Medicines Directorate was of the opinion that there were no economic, social, legal, administrative or other factors relevant to the placing of the substances under international control, and that the substances could be incorporated into the national list of substances or products that required authorization for their production, use, import or licit marketing.

11. The Government of Germany indicated that it had no objections to the scheduling recommendations made by WHO.

12. The Government of Japan reported that acetylfentanyl and MT-45 were controlled as "designated substances" under the Law on Securing Quality, Efficacy and Safety of Products including Pharmaceuticals and Medical Devices. If those substances were to be placed under international control, as recommended by WHO, Japan would enhance their regulation and designate them as "narcotics" under the Narcotics and Psychotropics Control Act.

13. The Government of Mexico reported no objection to placing the two substances under international control, as they represented a risk to public health and society and had no recognized therapeutic value. It reported that the national competent authorities had not reported any seizures of those substances, nor found any evidence of their existence in clandestine drug-manufacturing laboratories.

14. The Government of Morocco indicated that it had no objections to the scheduling recommendations made by WHO.

15. The Government of Poland reported that the WHO recommendations on MT-45 would be in conformity with the national Act on Prevention of Drug Addiction of 29 July 2005; however amendments to that legislation would be necessary to adopt the recommendation concerning acetylfentanyl.

16. The Government of the Russian Federation indicated that, according to information received from the Federal Drug Control Service, acetylfentanyl was already included in the list of narcotic drugs, psychotropic substances and their precursors that had been placed under control in the Russian Federation through Order Number 681 of 30 June 1998 of the Government of the Russian Federation.

17. The Government of Spain indicated that, owing to its pharmacological effects similar to morphine and fentanyl, Spain supported the inclusion of acetylfentanyl in Schedule I of the 1961 Convention. In addition, given that it was particularly liable to abuse, its consumption had caused fatalities and there were no relevant economic, social, legal, administrative or other factors identified, Spain also supported its inclusion in Schedule IV of the 1961 Convention. With regard to MT-45, the Government of Spain indicated that it was a synthetic opioid, with effects similar to morphine, posing a threat to public health and society, with no recognized therapeutic value and was being illicitly produced. For those reasons, Spain supported the inclusion of MT-45 in Schedule I of the 1961 Convention.

18. The Government of Switzerland reported that, owing to its potential to cause substantial harm and the fact that it had no medical or industrial use, acetylfentanyl was already under national control and thus it would support adding the substance to Schedule I and IV of the 1961 Convention, as amended. MT-45 was not yet documented in Switzerland and thus not under national control; however Switzerland would have no objection to adding it to Schedule I of the 1961 Convention, as amended.

19. The Government of Turkmenistan indicated that it had no objections to the scheduling recommendations made by WHO.

20. The Holy See reported that, with regard to any economic, social, legal, administrative and other factors related to the possible scheduling of the substances, it had no observations.

## Action to be taken by the Commission on Narcotic Drugs

21. The notification from the Director-General of WHO is before the Commission on Narcotic Drugs for its consideration, in accordance with the provisions of article 3, paragraph 3 (iii) and paragraph 5, of the 1961 Convention, which read as follows:

> "3. (iii) If the World Health Organization finds that the substance is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II or is convertible into a drug, it shall communicate that finding to the Commission which may, in accordance with the recommendation of the

World Health Organization, decide that the substance shall be added to Schedule I or Schedule II."

"5. If the World Health Organization finds that a drug in Schedule I is particularly liable to abuse and to produce ill effects (paragraph 3) and that such liability is not offset by substantial therapeutic advantages not possessed by substances other than drugs in Schedule IV, the Commission may, in accordance with the recommendation of the World Health Organization, place that drug in Schedule IV."

22. With regard to the decision-making process, the attention of the Commission is drawn to rule 58 of the rules of procedure of the functional commissions of the Economic and Social Council, which stipulates that decisions shall be made by a majority of the members present and voting. On the assumption that all members are present and voting, that means that for a decision to be adopted, an affirmative vote of at least 27 members of the Commission is required.

23. The Commission should therefore decide:

(a) Whether it wishes to include acetylfentanyl in Schedules I and IV of the 1961 Convention or, if not, what other action, if any, might be required;

(b) Whether it wishes to include MT-45 in Schedule I of the 1961 Convention or, if not, what other action, if any, might be required.

## II. Consideration of a notification from the World Health Organization concerning scheduling under the Convention on Psychotropic Substances of 1971

24. Pursuant to article 2, paragraphs 1 and 4, of the Convention on Psychotropic Substances of 1971, the Director-General of WHO, in her correspondence dated 7 December 2015, notified the Secretary-General that WHO recommended placing para-Methoxymethylamphetamine (PMMA) in Schedule I of the 1971 Convention. She also notified the Secretary-General that WHO recommended placing α-Pyrrolidinovalerophenone (α-PVP), para-Methyl-4-methylaminorex (4,4'-DMAR) and methoxetamine (MXE) in Schedule II of the 1971 Convention, and phenazepam in Schedule IV of that Convention. (See annex for the relevant extract of that notification.)

25. In accordance with the provisions of article 2, paragraph 2, of the 1971 Convention, the Secretary-General transmitted to all Governments a note verbale, dated 30 December 2015, annexing the notification and the information submitted by WHO in support of its recommendations.

26. As at 19 February 2016, the following 16 Governments had provided comments on economic, social, legal, administrative or other factors relevant to the recommended scheduling of those substances: Algeria, Austria, Chile, Colombia, Côte d'Ivoire, Croatia, El Salvador, Germany, Japan, Mexico, Morocco, Poland, Russian Federation, Spain, Switzerland and Turkmenistan.

27. The Holy See also provided comments on economic, social, legal, administrative or other factors relevant to the recommended scheduling of those substances.

28. The Government of Algeria indicated its support for the scheduling recommendations by WHO and reported that existing evidence justified the placement of those substances under international control.

29. The Government of Austria reported that it was facing difficulties in legally regulating new psychoactive substances, including those to be discussed by the Commission on Narcotic Drugs at its fifty-ninth session. While it agreed that effective measures against the increasingly rapid emergence of such substances were important, measures at the national level alone were insufficient and effective cooperation and coordination between all States was crucial. The Government of Austria indicated that it considered it necessary to develop new tailored instruments and mechanisms to tackle the phenomenon of new psychoactive substances, addressing the issue at its roots, hindering producers and dealers from rapidly replacing one substance by other substances as soon as they were legally placed under control. The New Psychoactive Substances Act of 2012 pursued a broad generic approach, defining classes of chemical substances, while targeting offences and criminal sanctions at the supply side only (production of new psychoactive substances and their distribution on the consumer market). The law further encouraged open talk about consumption behaviours from a public health perspective. The Government of Austria further reported that those substances recommended for being placed under international control that were not yet covered by the 2012 Act would soon be incorporated by an amendment.

30. The Government of Chile indicated that it considered it appropriate to place α-PVP under international control, as recommended by WHO. Given that the substance showed structural similarities and effects to other synthetic cathinones under international control, while having no licit nor industrial use in Chile, it was recommended that it also be placed under national control in Schedule I of Supreme Decree 867 of the Ministry of the Interior and Public Security.

31. The Government of Colombia reported that none of the substances recommended for international control had approved medical uses in Colombia. The Ministry of Justice and Law had no objection to the scheduling of those substances, as recommended by WHO. It further indicated that inclusion of those substances in the 1971 Convention would entail their inclusion in the Criminal Code of Colombia and in national legislation governing their regulation for medical and scientific uses. While forensic laboratories had the capacity to detect those substances, it would be necessary to strengthen the capacities of the police and the judicial and forensic authorities. The Government of Colombia further expressed its hope that placing those substances under international control would increase the availability of comprehensive public health measures to address their use in each country, in accordance with resolution 58/5 of the Commission on Narcotic Drugs. Lastly, the Government stressed that the scheduling of the recommended substances would represent an opportunity to strengthen international cooperation and critically review the system of classification, evaluation and decision-making for including new substances under international control and, where appropriate, propose any adjustments necessary based on scientific evidence that could be

generated once those substances were placed in the schedules, in implementation of resolutions 58/7 and 58/11 of the Commission on Narcotic Drugs.

32. The Government of Côte d'Ivoire indicated that it did not have any recent information on medical or scientific use of the substances recommended by WHO for scheduling. To prevent any illicit traffic and diversion, it agreed to placing those substances under international control.

33. The Government of Croatia reported that para-Methoxymethylamphetamine (PMMA), α-Pyrrolidinovalerophenone (α-PVP), para-Methyl-4-methylaminorex (4,4'-DMAR), methoxetamine (MXE) and phenazepam were already placed under national control, under Schedule I of the List of Psychotropic Substances and Plants.

34. The Government of El Salvador indicated that it had no records on the use or consumption of those substances. The National Medicines Directorate was of the opinion that there were no economic, social, legal, administrative or other factors relevant to the placing of the substances under international control, and that the substances could be incorporated into the national list of substances or products that required authorization for their production, use, import or licit marketing.

35. The Government of Germany indicated that it had no objections to the scheduling recommendations made by WHO.

36. The Government of Japan reported that para-Methoxymethylamphetamine (PMMA) and α-Pyrrolidinovalerophenone (α-PVP) have been strictly controlled nationally as "narcotics" under the Narcotics and Psychotropics Control Act in order to enhance their control since March 2013. Furthermore, the Government of Japan indicated that para-Methyl-4-methylaminorex (4,4'-DMAR) and Methoxetamine (MXE) were controlled as "designated substances" under the Law on Securing Quality, Efficacy and Safety of products including Pharmaceuticals and Medical Devices. If 4,4'-DMAR and MXE were placed under international control, as recommended by WHO, they would be designated as "narcotics" under national law to enhance their control. Phenazepam was not controlled under national legislation, but if it were to be placed under Schedule IV of the 1971 Convention, the Government of Japan would designate it as "psychotropic" under the national Narcotics and Psychotropics Control Act.

37. The Government of Mexico reported no objection to placing the recommended substances under international control, as they represented a risk to public health and society and had no recognized therapeutic use. It reported that the national competent authorities had not registered any seizures of those substances, nor found any evidence of their presence in any type of clandestine drug production laboratory.

38. The Government of Morocco indicated that it had no objections to the scheduling recommendations made by WHO. The Government of Morocco took into account the absence, with the exception of phenazepam, of any recognized therapeutic use of the substances.

39. The Government of Poland reported that the WHO recommendations on para-Methoxymethylamphetamine (PMMA) and methoxetamine (MXE) would be in conformity with the national Act on Prevention of Drug Addiction of 29 July 2005. In accordance with that legislation, α-Pyrrolidinovalerophenone (α-PVP) is listed as a psychotropic substance under group IV-P and therefore amendments to the Act

would be necessary to move the substance to group II. In addition, an appropriate amendment would also be necessary to reflect the recommendation concerning para-Methyl-4-methylaminorex (4,4'-DMAR).

40. The Government of the Russian Federation indicated that, according to information received from the Federal Drug Control Service, PMMA, alpha-PVP, 4,4'-DMAR and MXE were already included in the list of narcotic drugs, psychotropic substances and their precursors that had been placed under control in the Russian Federation through Order Number 681 of 30 June 1998 of the Government of the Russian Federation. In accordance with Russian legislation, phenazepam was included in the general list of medicinal products and had been widely used for medical purposes since the 1970s. There were no data on its abuse for non-medical purposes on a massive scale. It was indicated that the placement of phenazepam under international control, in line with the recommendation of WHO, could limit its use by patients who needed it. According to information from the Ministry of Industry and Trade of the Russian Federation, the finished pharmacological products of phenazepam were produced by six Russian enterprises. For that reason, the Russian Federation considered the inclusion of phenazepam in Schedule IV of the 1971 Convention to be unadvisable.

41. The Government of Spain reported that para-Methoxymethylamphetamine (PMMA) was produced illicitly and its abuse posed a particularly grave concern for public health and society, while having no recognized therapeutic value. Furthermore, α-Pyrrolidinovalerophenone (α-PVP) was a synthetic cathinone producing pharmacologically effects similar to those of methamphetamine and 3',4'-methylenedioxypyrovalerone (MDPV), which are already internationally controlled. Para-Methyl-4-methylaminorex (4,4'-DMAR) was a substance similar to 4-methylaminorex (4-MAR) and aminorex, which were also included in Schedules I and IV of the 1971 Convention. They were being illicitly produced and posed a substantial concern for public health, while having no recognized therapeutic value. With regard to methoxetamine (MXE), the Government of Spain indicated that it posed a considerable risk to public health, had no recognized therapeutic value and had been placed under national control, in Schedule II of Decree 2829/1977. For those reasons, the Government of Spain indicated its support for the scheduling recommendations by WHO.

42. The Government of Switzerland reported that there was no known medical or industrial use of para-Methoxymethylamphetamine (PMMA), the substance was under national control and Switzerland had no objection to adding it to Schedule I of the 1971 Convention. α-Pyrrolidinovalerophenone (α-PVP) and methoxetamine (MXE) had no known medical or industrial use and based on their potential to cause substantial harm, both substances were already under control in Switzerland. For that reason, it would support their placement in Schedule II of the 1971 Convention. With regard to para-Methyl-4-methylaminorex (4,4'-DMAR), given that the substance was not yet documented in Switzerland, it was not under national control; however Switzerland had no objection to adding it to Schedule II of the 1971 Convention. Lastly, the Government of Switzerland indicated that phenazepam was already under national control and thus it would support the recommendation to add it to Schedule IV of the 1971 Convention.

43. The Government of Turkmenistan indicated that it had no objections to the scheduling recommendations made by WHO.

44. The Holy See reported that, with regard to any economic, social, legal, administrative and other factors related to the possible scheduling of the substances, it had no observations.

## Action to be taken by the Commission on Narcotic Drugs

45. The notification by the Director-General of WHO is before the Commission on Narcotic Drugs for consideration, in accordance with the provisions of article 2, paragraph 5, of the 1971 Convention, which reads as follows:

> "5. The Commission, taking into account the communication from the World Health Organization, whose assessments shall be determinative as to medical and scientific matters, and bearing in mind the economic, social, legal, administrative and other factors it may consider relevant, may add the substance to Schedule I, II, III or IV. The Commission may seek further information from the World Health Organization or from other appropriate sources."

46. With regard to the decision-making process, the attention of the Commission is drawn to article 17, paragraph 2, of the 1971 Convention, which stipulates that the "decisions of the Commission provided for in articles 2 and 3 shall be taken by a two-thirds majority of the members of the Commission". From a practical point of view, this means that, for a decision to be adopted, an affirmative vote of at least 35 members of the Commission is required.

47. The Commission should therefore decide:

(a) Whether it wishes to place para-Methoxymethylamphetamine (PMMA) under Schedule I of the 1971 Convention or, if not, what other action, if any, might be required;

(b) Whether it wishes to place α-Pyrrolidinovalerophenone (α-PVP) under Schedule II of the 1971 Convention or, if not, what other action, if any, might be required;

(c) Whether it wishes to place para-Methyl-4-methylaminorex (4,4'-DMAR) under Schedule II of the 1971 Convention or, if not, what other action, if any, might be required;

(d) Whether it wishes to place methoxetamine (MXE) under Schedule II of the 1971 Convention or, if not, what other action, if any, might be required;

(e) Whether it wishes to place phenazepam under Schedule IV of the 1971 Convention or, if not, what other action, if any, might be required.

## Update on ketamine

48. The Director-General of WHO, in her communication to the Secretary-General, also made reference to decision 58/2 of the Commission on Narcotic Drugs of 13 March 2015, by which the Commission decided to postpone consideration of the proposal concerning the recommendation to place ketamine in Schedule IV of the Convention on Psychotropic Substances of 1971 and to request additional

information from WHO and other relevant sources. The Director-General of WHO in her communication reported that, based on an update review paper on ketamine, the Expert Committee on Drug Dependence unanimously agreed that it had found nothing in the updates, nor in what had been disclosed during its deliberations, that would give it reason to recommend a new pre-review or critical review of ketamine with a view to potentially changing its standing recommendation of 2014 that ketamine should not be placed under international control.

49. The Government of Mexico reiterated its support for the recommendation of WHO on ketamine and reported that the substance was classified as a controlled substance under national legislation, but was not completely prohibited owing to its therapeutic use. Diversion of ketamine for illicit purposes was not common and there was no knowledge of its synthesis in clandestine laboratories.

# Annex

## Extract of the notification from the Director-General of the World Health Organization to the Secretary-General dated 7 December 2015 concerning the scheduling of substances under the Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol, and the Convention on Psychotropic Substances of 1971, including the relevant extract from the thirty-seventh report of the Expert Committee on Drug Dependence

With reference to Article 2, paragraphs 1, 4 and 6 of the Convention on Psychotropic Substances (1971) and Article 3, paragraphs 1, 3 and 5 of the Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol, I am pleased to submit recommendations of the World Health Organization (WHO) as follows:

- Acetylfentanyl be placed in Schedule I and in Schedule IV of the Single Convention on Narcotic Drugs (1961), and that:
- MT-45 be placed in Schedule I of the Single Convention on Narcotic Drugs (1961), and that:
- para-Methoxymethylamphetamine (PMMA) be placed in Schedule I of the Convention on Psychotropic Substances (1971), and that:
- α-Pyrrolidinovalerophenone (α-PVP); para-Methyl-4-methylaminorex (4,4'-DMAR) and methoxetamine (MXE) be placed in Schedule II of the Convention on Psychotropic Substances (1971), and that:
- Phenazepam be placed in Schedule IV of the Convention on Psychotropic Substances (1971).

The recommendations and the assessments and findings on which they are based are set out in detail in the thirty-seventh report of the Expert Committee on Drug Dependence.

In decision 58/2 of 13 March 2015, the Commission on Narcotic Drugs decided to postpone the consideration of the proposal concerning the recommendation to place ketamine in Schedule IV of the Convention on Psychotropic Substances of 1971 and to request additional information from the World Health Organization and other relevant sources. Consequentially, an update review paper on ketamine was commissioned and provided to the Expert Committee. Following its deliberations the Committee unanimously agreed that it found nothing in the updates, nor in what was disclosed during its deliberations, that would give it reason to recommend a new pre-review or critical review of ketamine with a view to potentially change its standing recommendation of 2014 that ketamine should not be placed under international control. The current standing recommendation is consistent with the earlier recommendation made in 2012.

## Extract from the thirty-seventh report of the Expert Committee on Drug Dependence

### Substance recommended to be scheduled in Schedule I and Schedule IV of the Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol

*Acetylfentanyl*

Chemically, acetylfentanyl is *N*-phenyl-*N*-[1-(2-phenylethyl)-4-piperidinyl]acetamide. It is in the phenylpiperidine class of synthetic opioids that includes fentanyl, a Schedule I drug under the United Nations 1961 Single Convention on Narcotic Drugs. Acetylfentanyl has also been referred to as "desmethyl fentanyl".

Acetylfentanyl has not been previously reviewed by the Committee. A critical review was proposed based on information brought to WHO's attention that acetylfentanyl is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any Party.

Acetylfentanyl has effects similar to those of morphine and fentanyl that are included in Schedule I of the 1961 Single Convention on Narcotic Drugs. It has no recorded therapeutic use and its use has resulted in fatalities. Thus, because it meets the required condition of similarity, it is recommended that acetylfentanyl be placed in Schedule I of the Single Convention on Narcotic Drugs, 1961, as consistent with Article 3, paragraph 3 (iii) of that Convention in that the substance is liable to similar abuse and productive of similar ill effects as drugs in Schedule I. In addition, in accordance with Article 3, paragraph 5 of that Convention, considering acetylfentanyl is particularly liable to abuse and to produce ill-effects, and its liability is not offset by substantial therapeutic advantages, it is recommended it be included in Schedule IV of the Single Convention on Narcotic Drugs, 1961.

### Substance recommended to be scheduled in Schedule I of the Single Convention on Narcotic Drugs (1961), as amended by the 1972 Protocol

*MT-45*

Chemically, MT-45 is 1-cyclohexyl-4-(1,2-diphenylethyl)piperazine. MT-45 has two enantiomers and is commonly available as the racemic mixture.

MT-45 has not been previously reviewed by the Committee. A critical review was proposed based on information brought to WHO's attention that MT-45 is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any Party.

MT-45 is a compound with morphine-like effects. The Committee considered that the degree of risk to public health and society associated with the abuse liability and accompanying evidence warranted its placement under international control. Therapeutic use in humans has not been recorded. The Committee recommended that MT-45 be placed in Schedule I of the 1961 Single Convention, as amended by the 1972 Protocol.

**Substance recommended to be scheduled in Schedule I of the Convention on Psychotropic Substances (1971)**

*para-Methoxymethylamphetamine (PMMA)*

Chemically, PMMA (para-methoxymethylamphetamine) is 1-(4-methoxyphenyl)-*N*-methylpropan-2-amine. PMMA has two enantiomers and is commonly available as the racemic mixture.

PMMA has not been previously reviewed by the Committee. A critical review was proposed based on information brought to WHO's attention that PMMA is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any Party.

The Committee considered that the effects of PMMA are similar to PMA, a drug listed in Schedule I of the Convention on Psychotropic Substances of 1971, and the degree of risk to public health and society associated with its abuse is especially serious. The Committee also noted it has no recorded therapeutic use. The Committee considered that the evidence of its abuse warranted its placement under international control and recommended that PMMA be placed in Schedule I of the 1971 Convention.

**Substances recommended to be scheduled in Schedule II of the Convention on Psychotropic Substances (1971)**

*α-Pyrrolidinovalerophenone (α-PVP)*

Chemically, α-PVP (α-pyrrolidinovalerophenone) is 1-phenyl-2-(pyrrolidin-1-yl) pentan-1-one.

This synthetic cathinone is the desmethyl analogue of pyrovalerone that is listed in Schedule IV of the 1971 United Nations Convention on Psychotropic Substances. α-PVP has two enantiomers and is commonly available as the racemic mixture. α-PVP is closely related to 3',4'-methylenedioxypyrovalerone (MDPV) that has recently been placed in Schedule II of the United Nations Convention on Psychotropic Substances (1971).

α-PVP has not been previously reviewed by the Committee. A direct critical review was proposed based on information brought to WHO's attention that α-PVP is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any party.

The Committee considered that the degree of risk to public health and society associated with the abuse of α-PVP is substantial. Therapeutic usefulness has not been recorded. Its pharmacological effects are similar to methamphetamine and MDPV, psychostimulants listed in Schedule II of the 1971 Convention. The Committee considered that the evidence of its abuse warranted its placement under international control. As per the Guidance on the WHO review of psychoactive substances for international control, higher regard was accorded to the substantial public health risk than to the lack of therapeutic usefulness. The Committee recommended that α-PVP be placed in Schedule II of the 1971 Convention.

*para-Methyl-4-methylaminorex (4,4'-DMAR)*

Chemically, 4,4'-DMAR (para-methyl-4-methylaminorex) is 4-methyl-5-(4-methylphenyl)-4,5-dihydro-1,3-oxazol-2-amine. 4,4'-DMAR has four enantiomers and exists as racemic cis- or trans- forms. It is a synthetic substituted oxazoline derivative interpretable as an analogue of 4-methylaminorex (4-MAR) and aminorex, which are psychostimulants listed as Schedule I and Schedule IV substances, respectively, under the 1971 United Nations Convention on Psychotropic Substances.

4,4'-DMAR has not been previously reviewed by WHO. A critical review was proposed based on information brought to WHO's attention that 4,4'-DMAR is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any party.

As per the Guidance on the WHO review of psychoactive substances for international control, higher regard was accorded to the substantial public health risk than to the lack of therapeutic usefulness. The Committee considered that the degree of risk to public health and society associated with the abuse of 4,4'-DMAR is substantial. The Committee recommended that 4,4'-DMAR be placed in Schedule II of the 1971 Convention.

*Methoxetamine (MXE)*

Chemically, methoxetamine (MXE) is 2-(ethylamino)-2-(3-methoxyphenyl)cyclohexanone. It is a synthetic drug and belongs to the arylcyclohexylamine class like phencyclidine. Methoxetamine has two enantiomers and is commonly available as the racemic mixture.

During its 36th meeting, the WHO Expert Committee on Drug Dependence discussed the critical review report on methoxetamine and concluded that owing to the insufficiency of data regarding dependence, abuse and risks to public health, methoxetamine should not be placed under international control at that time, but be kept under surveillance. In 2014 the European Union decided to bring methoxetamine under control after a risk assessment by the EMCDDA. Furthermore new information on its abuse potential and more reports of fatal and non-fatal intoxications warranted a critical review for the 37th Expert Committee on Drug Dependence (ECDD).

Methoxetamine has been shown to have effects similar to phencyclidine, a compound listed in Schedule II of the Convention on Psychotropic Substances of 1971. The Committee considered that the degree of risk to public health and society associated with the abuse liability of methoxetamine is substantial. The Committee also noted it has no recorded therapeutic use. The Committee considered that the evidence of its abuse warranted its placement under international control. The Committee recommended that methoxetamine be placed in Schedule II of the 1971 Convention.

**Substance recommended to be scheduled in Schedule IV of the Convention on Psychotropic Substances (1971)**

*Phenazepam*

Chemically, phenazepam is 7-bromo-5-(2-chlorophenyl)-1,3-dihydro-2H-1,4-benzodiazepin-2-one.

Phenazepam has not been previously reviewed by the Committee. The Committee undertook a pre-review of the substance and considered that the information provided in the pre-review report was sufficient and indicated that dependence and harm caused by phenazepam was of such magnitude that proceeding directly into critical review within the meeting was warranted. All procedural requirements for a critical review, including two peer reviews, were fulfilled. Phenazepam has been shown to have effects similar to diazepam that is in Schedule IV of the Convention on Psychotropic Substances of 1971. The Committee considered that the degree of risk to public health and society associated with the abuse of phenazepam has a smaller but still significant risk to public health compared to substances in Schedules I-III and has a therapeutic usefulness from little to great. The Committee considered that the evidence of its abuse warranted its placement under international control. The Committee further recommended that phenazepam be placed in Schedule IV of the 1971 Convention.

**Substance recommended for critical review**

*Etizolam (INN)*

Chemically, etizolam is 4-(2-chlorophenyl)-2-ethyl-9-methyl-6H-thieno[3,2-f][1,2,4]triazolo[4,3-a][1,4]diazepine.

ECDD reviewed etizolam for the first time at its 26th meeting in 1989. At that time, the Committee rated the abuse liability of etizolam as moderate and the therapeutic usefulness as moderate to high. In view of the lack of clear-cut abuse, and of public health and social problems associated with its use, the Committee was unable to come to a decision concerning the scheduling of etizolam and recommended that a decision be deferred to the 27th meeting of the Committee.

At its 27th meeting in 1990, the Committee again rated the abuse liability of etizolam as low to moderate and the therapeutic usefulness as moderate to high. The Committee noted few public health and social problems associated with its use at that time and considered that the degree of seriousness of these problems was not great enough to warrant international control. Consequently, the Committee did not recommend scheduling of etizolam in 1990.

At the 37th ECDD, on the basis of the evidence available regarding dependence, abuse and risks to public health, the Committee recommended that a critical review of etizolam is warranted for a future meeting.

**Substance recommended for surveillance**

*4-Fluoroamphetamine (4-FA)*

Chemically, 4-FA (4-fluoroamphetamine) is 1-(4-fluorophenyl)propan-2-amine. 4-FA has two enantiomers and is commonly available as the racemic mixture.

4-FA has not been previously reviewed by the Committee. A critical review was proposed based on information brought to WHO's attention that 4-FA is clandestinely manufactured, poses a risk to public health and society, and has no recognized therapeutic use by any Party.

Owing to the current insufficiency of data regarding dependence, abuse and risks to public health (including risks to the individual), the Committee recommended that 4-FA not be placed under international control at this time, but be kept under surveillance.

**Update on cannabis**

The Commission on Narcotic Drugs, in resolution 52/5, expressed that it "... looks forward to an updated report on cannabis by the Expert Committee, subject to the availability of extrabudgetary resources", and the Report of the International Narcotics Control Board for 2014 reiterated, "... its invitation to WHO to evaluate the potential medical utility of cannabis and the extent to which cannabis poses a risk to human health". WHO therefore commissioned an update report paper on cannabis and cannabis resin.

An update on the scientific literature of cannabis was presented and reviewed during the session including the pharmacology, toxicology and the claimed therapeutic applications. The Committee then deliberated about the content of the material presented. The Committee requested the Secretariat to begin collecting data towards a pre-review of cannabis, cannabis resin, extracts and tinctures of cannabis at a future meeting. Furthermore it specifically requested the Secretariat to place emphasis on any therapeutic advantages that they may have relative to other existing therapeutics.

**Update on ketamine**

Updates on ketamine were presented in which the levels and consequences of its abuse, and new potential medical applications were identified. Levels of ketamine abuse appeared to be declining in many countries worldwide. Potential new therapeutic uses were identified including depression and refractory status epilepticus. Evaluation of ketamine for treating depression is in Phase III studies. Ketamine is widely used as an anaesthetic agent for human and veterinary use globally. Ketamine is the anaesthetic agent of choice in low-income countries and emergency situations where there are limitations in trained medical personnel, anaesthesia machines, and consistent sources of electricity.

Following its deliberations, the Committee unanimously agreed that it found nothing in the updates, nor in what had been disclosed during its deliberations, that would give it reason to recommend a new pre-review or critical review of ketamine with a view to potentially change its standing recommendation of 2014 that ketamine should not be placed under international control.